Janet A. Sullivan, MS, LCPC, LPC
1325 Remington Road, Suite C
Schaumburg, IL 60173
847-946-2795

CONSENT TO TREATMENT FORM

I consent to take part in treatment with Janet A. Sullivan, MS, LCPC, LPC.

I have received and read the **Intake Information** form explaining the risks and benefits of treatment, the fees for services, and other policies and agree to its terms.

I have received and read the **Privacy Notice** as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the Intake Information or Privacy Notice that I do not understand.

I understand the **risks and limitations to confidentiality with the use of electronic correspondence** including email, text and scheduling. I understand that I can choose to limit communication to phone and in-person correspondence.

I understand that **I am responsible for my bill**. I understand that the regular hourly rate for counseling services is $150 (individual) or $180 (couple/family) and I agree to pay the hourly rate for any professional services performed during the course of my treatment. I understand that Janet Sullivan, MS, LCPC, LPC may elect to end treatment if timely payment for services is not made.

I understand that I will be charged $150 (ind) or $180 (couple) for failing to show or for failing to give at least **24 hours advance notice when canceling an appointment**. This fee must be paid prior to scheduling future appointments.

I authorize Janet A. Sullivan, MS, LCPC, LCP to charge the credit/debit card account provided in my intake information for services rendered, no show or late cancellation fees, unless I had made other arrangements for payment. By signing below, I acknowledge that I am legally able to authorize payments for the above listed credit/debit card. I have read, understand, and agree to the payment arrangements.

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Client Signature Date

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Parent/Guardian Signature (If client is under age 18) Date

Dated: 1/1/15, revised 6/15/17; 8/1/21; 10/26/21